

9504

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Talbot</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b> <b>Caroline</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Preston</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Memorial Hospital</b>				d. STREET ADDRESS <b>058-2</b>			
3. NAME OF DECEASED (Type or print) First <b>Viola</b> Middle <b>Griffith</b> Last <b>Brinsfield</b>				4. DATE OF DEATH Month <b>August</b> Day <b>9</b> Year <b>1958</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 8, 1892</b>		9. AGE (In years last birthday) <b>66</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Zorah Brinsfield</b>				14. MOTHER'S MAIDEN NAME <b>Agnes Pardoe</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>ukn.</b>		17. INFORMANT <b>Mrs. Mildred Douglas, Preston, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Melanoma of right breast</b> 190.7 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>E. C. H. Schmidt</b>				DATE SIGNED <b>10 Aug 58</b>			
PHYSICIAN'S NAME (Type) <b>E. C. H. Schmidt</b>				ADDRESS (Street, city or town, state) <b>219 S. Washington St. Easton 16, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/12/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Union Grove Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Caroline County, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry M. Hollis, etc.</b>				ADDRESS <b>Preston, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>P 17 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



09498

9505

# CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Talbot</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>2 hrs. 40 min</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Denton</u> <u>05x-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u>212 N. 5<sup>th</sup> ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Granville</u>		First Middle Last <u>Brown.</u>		4. DATE OF DEATH Month <u>August</u> Day <u>5</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 19/1903</u>	9. AGE (In years last birthday) <u>54</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plummer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Plummer</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Harvey Brown.</u>		14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Thrombosis</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <u>Denton, Md.</u>		20g. (County) <u>Denton</u>		20h. (State) <u>Md.</u>	
21. I certify that I attended the deceased from <u>1958</u> , to <u>1958</u> , that I last saw the deceased alive on <u>Aug 6, 1958</u> , and that death occurred at <u>5:45 P.M.</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>E.C.H. Schmidt</u>		M.D. <u>219 S. West Washington St. Aug 6, 1958</u>		DATE SIGNED <u>Aug 6, 1958</u>	
PHYSICIAN'S NAME (Type) <u>E.C.H. Schmidt</u>		<u>Easton 16 Maryland</u>			
22a. BURIAL, CREMATION, or other disposal <u>BURIAL</u>		22b. DATE THEREOF <u>AUG. 10, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Spring Grove</u>	
22d. LOCATION (City, town, or county) <u>Denton, Md.</u>		22e. (State) <u>Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. V. Moore</u>		ADDRESS <u>Denton, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 8 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. V. Moore</u>					

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached or use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55



9506

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton.</u>				c. LENGTH OF STAY IN 1b <u>13 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ruth</u> Middle <u>W</u> Last <u>Chapman</u>				4. DATE OF DEATH Month <u>August</u> Day <u>11</u> Year <u>1958</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 29, 1891</u>	
9. AGE (In years last birthday) <u>67 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Indian a</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Dr. Kent Wheelock.</u>				14. MOTHER'S MAIDEN NAME <u>Matilda Henderson.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>J. Halbrook Chapman</u> Address <u>Wittman Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Myocardial infarction due</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>abnormal coronary thrombosis</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>14 hrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>8/11</u> , 19 <u>58</u> , to <u>8/11</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8/11</u> , 19 <u>58</u> , and that death occurred at <u>4:55 PM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>Thorston Harrison</u> M.D. <u>Carlton Mayhew</u> <u>12 Aug. 58</u>							
PHYSICIAN'S NAME (Type) <u>THORSTON HARRISON</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Aug 14, 58 Woodlawn Cemetery Newark</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Carlton Mayhew</u> ADDRESS <u>Carlton Md.</u>				24d. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <u>Aug 13 '58</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

NAME OF DECEASED MARY ANN		SEX F		AGE 40	
DATE OF DEATH 1918		TIME OF DEATH 10:00 AM		PLACE OF DEATH HOME	
CAUSE OF DEATH DISEASE OF THE HEART		MANNER OF DEATH NATURAL		PLACE OF BIRTH BALTIMORE, MD	
OCCASION OF DEATH Sudden		PREVIOUS ILLNESS None		OCCUPATION None	
SIGNATURE OF PHYSICIAN J. H. Smith		SIGNATURE OF CORONER J. H. Smith		SIGNATURE OF WITNESS J. H. Smith	
CERTIFICATE OF DEATH I hereby certify that the above is a true and correct statement of the facts as they came to my knowledge and belief.		I hereby certify that the above is a true and correct statement of the facts as they came to my knowledge and belief.		I hereby certify that the above is a true and correct statement of the facts as they came to my knowledge and belief.	

This certificate is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, and a copy of the same is to be sent to the local health officer of the city or county in which the death occurred.

VS A15 (4)  
15M 9/55

to

9507

Item 13 FilmG232 8-21-58 et

# CERTIFICATE OF DEATH

Reg. Dist. No.

09500

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE		MARYLAND		b. COUNTY		Queen Ann	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		EASTON		c. LENGTH OF STAY IN 1b		27 da.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Centreville 17x-2 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Memorial Hospital		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		Mina		First		Middle		Last		4. DATE OF DEATH	
										Month 8 Day 15 Year 1958	
5. SEX		Fe		6. COLOR OR RACE		W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
										10-17-1891 6p	
9. AGE (In years last birthday) yrs.		66		IF UNDER 1 YEAR		Months		Days		Hours	
										Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
								Maryland		USA	
13. FATHER'S NAME		Daniel Haddaway		14. MOTHER'S MAIDEN NAME		Manie Frampton					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown)				16. SOCIAL SECURITY NO.				17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		Coronary thrombosis Coronary atherosclerosis		INTERVAL BETWEEN ONSET AND DEATH sudden (?)/							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from 8/14/58 to 8/15/58, that I last saw the deceased alive on 8/14/58, and that death occurred at 6:10 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		DATE SIGNED							
ACTUAL SIGNATURE		MURTON HARRISON M.D.		ARTHUR S. HARRIS							
PHYSICIAN'S NAME (Type)		THURSTON HARRISON									
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)					
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE					
C. D. DUNSMORE		TILLY		AUG 19 1958		ARTHUR S. HARRIS					

CERTIFICATE OF DEATH

1903



1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. DATE OF BIRTH <i>Jan 15 1858</i>		5. PLACE OF BIRTH <i>St. Louis, Mo.</i>		6. OCCUPATION <i>Teacher</i>	
7. DATE OF DEATH <i>Dec 10 1903</i>		8. TIME OF DEATH <i>10:30 AM</i>		9. PLACE OF DEATH <i>Home</i>		10. CAUSE OF DEATH <i>Heart Disease</i>		11. DISEASE OR INJURY <i>Myocardial Infarction</i>		12. MEDICAL HISTORY <i>None</i>	
13. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>		14. SIGNATURE OF WITNESS <i>John Doe</i>		15. SIGNATURE OF DECEASED <i>John Doe</i>		16. SIGNATURE OF NEAREST RELATIVE <i>John Doe</i>		17. SIGNATURE OF CLERK <i>John Doe</i>		18. SIGNATURE OF REGISTRAR <i>John Doe</i>	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT, BALTIMORE, MARYLAND, FOR THE PURPOSE OF RECORDING AND STATISTICS.



## CERTIFICATE OF DEATH

Reg. Dist. No.

9508

1. PLACE OF DEATH o. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>				c. LENGTH OF STAY IN TB <u>16 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>THE MEMORIAL HOSPITAL</u>				d. STREET ADDRESS <u>HARMONY</u>			
3. NAME OF DECEASED (Type or print) First <u>BELLE</u> Middle <u>-</u> Last <u>FOLS</u>				4. DATE OF DEATH Month <u>August</u> Day <u>6</u> Year <u>1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 13, 1886</u>	9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES KEMP</u>				14. MOTHER'S MAIDEN NAME <u>JENNIE M. FLEETWOOD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>-</u>			
17. INFORMANT <u>CHARLIE FOLS, PRESTON, MD., RFD.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolus</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pelvic thrombosis</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Granuloma pneumonia 1947</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour _____ o. m. _____ p. m. _____ Month _____ Day _____ Year <u>19</u>	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>11 A.</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u>				ADDRESS (Street, city or town, state) <u>219 S. Washington St. Federsburg, Md.</u>			
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>				DATE SIGNED <u>Aug 16, 1958</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>AUG. 9, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>HILL CREST CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>FEDERALSBURG, MD.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Frawley</u>				ADDRESS <u>Federalburg Md.</u>		24a. REC'D BY REGISTRAR <u>AUG 14 1958</u>	
				24b. REGISTRAR'S SIGNATURE <u>John S. Frank</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9509

## CERTIFICATE OF DEATH

Reg. Dist. No. 09502

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Denton</u> 05X-2 ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Debbie</u> Middle <u>Ellen</u> Last <u>Fountain</u>				4. DATE OF DEATH Month <u>August</u> Day <u>11</u> Year <u>1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 8, 1887</u>	9. AGE (In years lost birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____ Hours _____		IF UNDER 24 HRS. Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>John Devore</u>				14. MOTHER'S MAIDEN NAME <u>Debbie Adams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>yes</u>		17. INFORMANT Address <u>Charles Fountain - Denton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid hemorrhage</u> 330x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute myocardial infarction</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/6</u> , 19 <u>58</u> , to <u>8/11</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8/11</u> , 19 <u>58</u> , and that death occurred at <u>4:37 P.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert W. Trever</u>				ADDRESS (Street, city or town, state) <u>Memorial Hospital, Easton</u> DATE SIGNED <u>8/12/58</u>			
PHYSICIAN'S NAME (Type) <u>Robert W. Trever</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>Aug 14, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Shelburne Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Federalsburg, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry Williams</u> ADDRESS <u>Federalsburg, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 18 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, giving the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1, 2, and 3 may be retained for your files. TO FUNERAL DIRECTOR: Pages 1, 2, and 3 should be used as a burial-transit permit. File pages 1, 2, and 3 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9510

09503

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>2 1/2 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u> RFP #1	
3. NAME OF DECEASED (Type or print) <u>Maurice</u> First <u>William</u> Middle <u>Frizzell</u> Last <u>Frizzell</u>		4. DATE OF DEATH <u>Aug. 1</u> 1958. Month <u>Aug.</u> Day <u>1</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/14/11</u>
9. AGE (In years last birthday) <u>46</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Consturion</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY	13. FATHER'S NAME <u>John C. Frizzell</u>	14. MOTHER'S MAIDEN NAME <u>Katherine Kempf</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WW2</u>	16. SOCIAL SECURITY NO. <u>213-05-7354</u>	17. INFORMANT <u>Mrs. Elizabeth Frizzell</u> Address <u>Montg. Rd. Ellicott City, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Severe Brain injuries</u> <u>816x</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Auto accident</u> (c), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Car sideswiped by another</u>	
20c. TIME OF INJURY Month, Day, Year <u>153</u> Hour a. m. <u>7-30</u> 1958	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 50</u>	20f. (City or town) <u>nr. Easton Talbot</u> (County) <u>Ind</u> (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Louis M. WELT</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>WELT</u>		DATE SIGNED <u>8-2-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>8/4/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge</u>	22d. LOCATION (City, town, or county) <u>Elkridge</u> (State) <u>Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F.C. HIGINBOTHOM</u>		24. REC'D BY REGISTRAR <u>Aug 6 '58</u> 24b. REGISTRAR'S SIGNATURE <u>W. H. H. H.</u>	
ADDRESS <u>Ellicott City, Md.</u>		DATE <u>AUG 6 '58</u>	



1

3210

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

NAME: *John Doe*  
 SEX: *Male*  
 AGE: *45*  
 RACE: *White*  
 BIRTH DATE: *10-15-1900*  
 BIRTH PLACE: *Baltimore, Md.*  
 OCCUPATION: *Teacher*  
 RESIDENCE: *123 Main St, Baltimore, Md.*  
 DEATH DATE: *11-10-1945*  
 DEATH PLACE: *Home*  
 CAUSE OF DEATH: *Heart Disease*  
 MANNER OF DEATH: *Natural*

DIAGNOSIS: *Myocardial Infarction*  
 HISTORY: *Long history of hypertension and coronary artery disease.*  
 PHYSICAL EXAMINATION: *At death, patient was found in bed, unconscious, with no pulse.*  
 POST-MORTEM EXAMINATION: *None performed.*  
 SIGNATURE: *Dr. J. H. Smith*  
 TITLE: *Physician*  
 ADDRESS: *456 Oak St, Baltimore, Md.*  
 TELEPHONE: *123-4567*

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9527  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Item 4 Film 0232 8-18-58 et  
CERTIFICATE OF DEATH

09504

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ST MICHAELS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>KIDVISTA NURSING HOME</u>				d. STREET ADDRESS <u>178-2</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>J. Steve Goodhand</u>				4. DATE OF DEATH Month Day Year <u>Aug. 7, 1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN. 7 1875</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		10. AGE (In years last birthday) <u>82</u> yrs.		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED RURAL MAIL CARRIER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>			
13. FATHER'S NAME <u>Charles F. Goodhand</u>				14. MOTHER'S MAIDEN NAME <u>CAROLINE Bruen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Dr. Charles Goodhand</u>			
17. INFORMANT <u>Dr. Charles Goodhand</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarction acute - mu'dab</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>atherosclerotic coronary heart</u> DUE TO (c) <u>chronic cardiac failure</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>chronic cardiac failure</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>1-27-</u> , 19 <u>58</u> , to <u>8-6-</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>5-6-</u> , 19 <u>58</u> , and that death occurred at <u>4:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Guy M. Reeser Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>St Michaels Md</u>			
PHYSICIAN'S NAME (Type) <u>Guy M. Reeser Jr.</u>				DATE SIGNED <u>8-8-58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Aug 11, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Stevensville Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Stevensville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Maurice E. Newman</u>				24a. REC'D BY REGISTRAR <u>Easton, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
JAMES H. HARRIS		Male		45		Jan 15, 1885		Baltimore, Md.		Carpenter		Married		White	
9. DATE OF DEATH		10. TIME OF DEATH		11. PLACE OF DEATH		12. CAUSE OF DEATH		13. DISEASE OR INJURY		14. PERIOD OF ILLNESS		15. PREVIOUS ILLNESS		16. SIGNATURE OF PHYSICIAN	
Jan 20, 1935		10:30 AM		Home		Heart Disease		Coronary Artery Sclerosis		2 weeks		None		J. H. Harris, M.D.	
17. SIGNATURE OF REGISTRAR		18. SIGNATURE OF WITNESS		19. SIGNATURE OF DECEASED		20. SIGNATURE OF NEAREST RELATIVE		21. SIGNATURE OF CLERGYMAN		22. SIGNATURE OF BURIAL OFFICIAL		23. SIGNATURE OF FUNERAL HOME		24. SIGNATURE OF CEMETERY	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	

THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT IT IS CORRECTLY FILLED OUT AND THAT THE DEATH IS PROPERLY RECORDED. THE REGISTRAR IS NOT RESPONSIBLE FOR THE CONTENTS OF THIS CERTIFICATE.

9511

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN lb <u>8 mo.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1109 Park Avenue</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Donald</u> Middle <u>Alexander</u> Last <u>Green</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>30</u> Year <u>1958</u>			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W.</u>		7. MARried <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 14, 1897</u>	
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>18</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>A. J. S. Co.</u>			
11. BIRTHPLACE (State or foreign country) <u>Tennessee</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Joshua Green</u>				14. MOTHER'S MAIDEN NAME <u>Georgina Hepburn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>U. S. Army</u>				16. SOCIAL SECURITY NO. <u>087-07-8490</u>			
17. INFORMANT <u>Leahore D. Green</u>				Address <u>Easton Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> <u>465X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>002X Pulmonary TB</u> <u>Coronary atherosclerosis</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Oct 1957</u> , to <u>20 Aug 1958</u> , that I last saw the deceased alive on <u>28 Aug 1958</u> , and that death occurred at <u></u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thorston Harrison</u> M.D.				ADDRESS (Street, city or town, state). <u>Easton Maryland</u>			
DATE SIGNED <u>Sept 58</u>							
PHYSICIAN'S NAME (Type) <u>THORSTON HARRISON</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Sept 2, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Forest Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edwin Black</u>				ADDRESS <u>Easton Md.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 2 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon 2 and 3 and retain them for 72 hours after the burial, cremation, or removal, and in any event within 72 hours after the death.





## CERTIFICATE OF DEATH

Reg. Dist. No.

9512

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>TALBOT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>				c. LENGTH OF STAY IN 1b <u>2 days.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Virginia</u> Middle <u></u> Last <u>HAMILTON</u>				4. DATE OF DEATH Month <u>8</u> Day <u>28</u> Year <u>1958</u>			
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 24, 1876</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hw.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Joseph Himelwright</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Garrett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)				16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT Address <u>Ruth Wharton St Michaels Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>atherosclerotic cerebrovascular</u> DUE TO (c) <u>atherosclerotic coronary heart d</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension - Essential vascular</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>2-23</u> , 19 <u>54</u> , to <u>8-28</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8-28</u> , 19 <u>58</u> , and that death occurred at <u>7:25</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>St Michaels Md</u> DATE SIGNED <u>8-28-58</u>							
ACTUAL SIGNATURE <u>Thy M Greener</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Thy M Greener</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>Sept 30, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chlor Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>St. Michaels Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>St. Hamilton Harrison, St. Michaels Md.</u> ADDRESS <u></u>				24a. REC'D BY REGISTRAR DATE <u>SEP 2 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy of pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No.

09507

9513

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u>130 West St.</u>	
3. NAME OF DECEASED (Type or print) <u>Mrs. Stella</u> First Middle Last <u>Harrison</u>		4. DATE OF DEATH <u>August 30</u> 19 <u>58</u> Month Day Year	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 15, 1895</u> 62 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Med.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Mr. George W. Greenwood</u>		14. MOTHER'S MAIDEN NAME <u>Georgina Hynton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Carlton</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastatic carcinoma</u> 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>carcinoma of bowel</u> DUE TO (c) <u>?</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April</u> , 19 <u>58</u> to <u>8/30/58</u> , that I last saw the deceased alive on <u>8/30</u> , 19 <u>58</u> , and that death occurred at <u>4:30 A.</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Carlton</u> DATE SIGNED <u>8/1/58</u>			
ACTUAL SIGNATURE <u>P. E. Cox</u> M.D.		PHYSICIAN'S NAME (Type) <u>P. E. Cox</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept. 1, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Easton, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Maurice E. Newman, Jr.</u> ADDRESS <u>Easton, Md.</u>		24a. REC'D BY REGISTRAR <u>SEP 3 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Charles E. Howard</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon 2 and 3 and return them to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1917

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]	
AGE [Faint text, possibly "45"]		DATE OF BIRTH [Faint text, possibly "Jan 1, 1872"]	
PLACE OF BIRTH [Faint text, possibly "Boston, Mass."]		OCCUPATION [Faint text, possibly "Clerk"]	
CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		PLACE OF DEATH [Faint text, possibly "Home"]	
TIME OF DEATH [Faint text, possibly "10:30 AM"]		DATE OF DEATH [Faint text, possibly "Dec 15, 1917"]	
SIGNATURE OF PHYSICIAN [Faint signature]		SIGNATURE OF REGISTRAR [Faint signature]	
CERTIFICATE OF DEATH [Faint text]		[Faint text]	

CRIMINAL RECORDS

This is to certify that the above is a true and correct copy of the original record as it appears in the files of the Department of Health, Boston, Massachusetts, and that the same has been compared with the original and found to be correct.

WITNESSED my hand and the seal of the Department of Health, Boston, Massachusetts, this 15th day of December, 1917.

REGISTRAR

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 10, 11, 12, 13, 14 Film G233 9-15-58 et

CERTIFICATE OF DEATH

9514

09508

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Talbot</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b>		c. LENGTH OF STAY IN 1b <b>7 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Memorial Hospital</b>		d. STREET ADDRESS <b>Denton RFD (Hobbs)</b>	
3. NAME OF DECEASED (Type or print) First <b>Orem</b> Middle <b>Haywood</b> Last <b>Henry</b>		4. DATE OF DEATH Month <b>August</b> Day <b>31</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 1878</b>
9. AGE (In years last birthday) <b>80</b> yrs.		10. IF UNDER 1 YEAR Months <b>80</b> Days <b>80</b> Hours <b>80</b> Min. <b>80</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Henry</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Address</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac failure</b> DUE TO <b>4443X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive C-V disease</b> DUE TO <b>(?)</b> (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Thrombosis of the abdominal aorta</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>25 Aug., 1958</b> , to <b>31 Aug., 1958</b> , that I last saw the deceased alive on <b>31 Aug., 1958</b> , and that death occurred at <b>2:10a M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Thurston Harrison</b> M.D.		ADDRESS (Street, city or town, state) <b>Denton Maryland</b>	
DATE SIGNED <b>3 Sept 58</b>			
PHYSICIAN'S NAME (Type) <b>THURSTON HARRISON</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>Sept 3 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Denton</b>		22d. LOCATION (City, town, or county) (State) <b>Denton Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. V. Moore &amp; Son</b>		ADDRESS <b>Denton</b>	
24a. REC'D BY REGISTRAR DATE <b>SEP 5 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>	



CERTIFICATE OF DEATH

5014

NAME OF DECEASED [Illegible]		SEX [Illegible]		AGE [Illegible]	
PLACE OF BIRTH [Illegible]		DATE OF BIRTH [Illegible]		PLACE OF DEATH [Illegible]	
OCCUPATION [Illegible]		CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]	
DATE OF DEATH [Illegible]		TIME OF DEATH [Illegible]		PLACE OF INTERMENT [Illegible]	
NAME OF PHYSICIAN [Illegible]		NAME OF FUNERAL HOME [Illegible]		NAME OF MINISTER [Illegible]	
NAME OF NEXT OF KIN [Illegible]		NAME OF SURVIVOR [Illegible]		NAME OF WITNESS [Illegible]	
NAME OF REGISTRAR [Illegible]		NAME OF CLERK [Illegible]		NAME OF ASSISTANT [Illegible]	

## CERTIFICATE OF DEATH

09509

Reg. Dist. No.

9515

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clifton</u>	
c. LENGTH OF STAY IN 1b <u>3 hrs</u>		d. STREET ADDRESS <u>Easton Memorial Hospital</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Gardner</u> Middle <u>A.</u> Last <u>Higgins</u>		4. DATE OF DEATH Month <u>August</u> Day <u>3</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 27 1899</u>
9. AGE (In years last birthday) <u>59</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self Emp.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Daniel E. Higgins</u>		14. MOTHER'S MAIDEN NAME <u>Augusta Godwin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at 1:25 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE <u>E. C. H. Schmidt</u> M.D. <u>219 S. Westinghouse St</u> <u>4 Aug 58</u>	DATE SIGNED
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u> <u>Easton 16, Maryland</u>	

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Aug 5, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oxford Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Oxford Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Hamilton Harrison</u> ADDRESS <u>St. Michaels</u>		24a. REC'D BY REGISTRAR <u>12 1958</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Krueger</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. PLACE OF BIRTH <i>John Doe</i>	
3. SEX <i>Male</i>		4. AGE <i>45</i>	
5. OCCUPATION <i>Teacher</i>		6. CAUSE OF DEATH <i>Heart Disease</i>	
7. DATE OF DEATH <i>Jan 15 1925</i>		8. TIME OF DEATH <i>10:30 AM</i>	
9. PLACE OF DEATH <i>Home</i>		10. SIGNATURE OF DECEASED <i>John Doe</i>	
11. SIGNATURE OF WITNESS <i>John Doe</i>		12. SIGNATURE OF PHYSICIAN <i>John Doe</i>	
13. SIGNATURE OF CLERK <i>John Doe</i>		14. SIGNATURE OF REGISTRAR <i>John Doe</i>	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND A COPY OF THE SAME IS TO BE FURNISHED TO THE NEAREST RELATIVE OF THE DECEASED.

9516

## CERTIFICATE OF DEATH

09510

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Queen Anne's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Anne</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Memorial Hospital</u>				d. STREET ADDRESS <u>17X-2</u>			
3. NAME OF DECEASED (Type or print) First <u>Baby "B"</u> Middle <u>Johnson</u> Last <u>Johnson</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>8</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 7, 1958</u>	9. AGE (In years lost birthday) yrs. <u>12</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Memorial Hosp Easton Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Hilda Hammond</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>John Hammond Johnson</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atelectasis</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> <u>12 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/7</u> , 19 <u>58</u> , to <u>8/8</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8/7</u> , 19 <u>58</u> , and that death occurred at <u>5:15 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John E. Bayliff</u> M.D.				ADDRESS (Street, city or town, state) <u>205 E. E. Ave Easton Md</u> DATE SIGNED <u>8-14-58</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremated</u>		22b. DATE THEREOF <u>8/11/58</u>		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Memorial Hospital Easton Md</u> ADDRESS				24a. REC'D BY REGISTRAR <u>Aug 15 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanes</u>	

2280238XVI

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon 1 and 2 and fill with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 65		4. RACE White		5. DATE OF BIRTH 1885		6. PLACE OF BIRTH Maryland		7. DATE OF DEATH 1950		8. PLACE OF DEATH Baltimore, Maryland	
9. OCCUPATION Teacher		10. MARITAL STATUS Married		11. CAUSE OF DEATH Heart Disease		12. MANNER OF DEATH Natural		13. MEDICAL HISTORY Hypertension, Atherosclerosis		14. PREVIOUS ILLNESS None		15. MEDICAL ATTENDANCE Physician		16. BURIAL PLACE Catholic Cemetery	
17. SIGNATURE OF DECEASED		18. SIGNATURE OF NEXT OF KIN		19. SIGNATURE OF PHYSICIAN		20. SIGNATURE OF REGISTRAR		21. SIGNATURE OF CLERK		22. SIGNATURE OF WITNESS		23. SIGNATURE OF WITNESS		24. SIGNATURE OF WITNESS	

10-10-50  
BALTIMORE, MARYLAND  
JAMES H. HARRIS  
1885-1950  
HEART DISEASE  
NATURAL  
CATHOLIC CEMETERY  
BALTIMORE, MARYLAND



9528

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Talbot</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wittman</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>None</b>				d. STREET ADDRESS <b>/</b>			
3. NAME OF DECEASED (Type or print) First <b>Ollie</b> Middle <b>E.</b> Last <b>Marshall</b>				4. DATE OF DEATH Month <b>8</b> Day <b>17</b> Year <b>1958</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>6-18-1912</b>	
9. AGE (In years last birthday) <b>46</b> yrs.		IF UNDER 1 YEAR Months <b>46</b> Days <b>17</b> Hours <b>1958</b>		IF UNDER 24 HRS. Months <b>46</b> Days <b>17</b> Hours <b>1958</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waterman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Crab &amp; Oyster</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>US</b>							
13. FATHER'S NAME <b>John W. Marshall</b>				14. MOTHER'S MAIDEN NAME <b>Eva Moore</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>220-01-5957</b>		17. INFORMANT <b>Mrs. Harrison Ross</b> Address <b>St. Michaels, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>322.1</b> DUE TO <b>Coronary atherosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic alcoholic</b> DUE TO (c) <b>10 yrs</b>				INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>1958</b> to <b>Aug 17, 1958</b> , that I last saw the deceased alive on <b>1958</b> , and that death occurred at <b>2A</b> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Wm M Reeser</b> M.D.				DATE SIGNED <b>Aug 17 1958</b>			
PHYSICIAN'S NAME (Type) <b>Wm M REESER MD</b>				ADDRESS <b>Tilghman Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-19658</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Tilghman Methodist</b>		22d. LOCATION (City, town, or county) (State) <b>Tilghman Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur L. Hanes</b>				24a. REC'D BY REGISTRAR <b>DATE AUG 21 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanes</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove, and in any event within 72 hours after death, the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carders. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9517

CERTIFICATE OF DEATH

09511

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>TALBOT</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>TALBOT</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EASTON</b>				c. LENGTH OF STAY IN TB <b>3 hrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>40 EASTON</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>EASTON Memorial Hosp.</b>				d. STREET ADDRESS <b>116 GLENWOOD AVENUE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>BOY</b> Middle <b>-</b> Last <b>McCLAIN</b>				4. DATE OF DEATH Month <b>August</b> Day <b>26</b> Year <b>1958</b>			
5. SEX <b>m</b>		6. COLOR OR RACE <b>w</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-26-58</b>	
9. AGE (In years last birthday) <b>3</b>		IF UNDER 1 YEAR Months <b>3</b> Days <b>3</b> Hours <b>3</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>GEORGE David McCLAIN JR</b>		14. MOTHER'S MAIDEN NAME <b>FRANCES WINIFRED HARRISON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>136-26-1000</b>		17. INFORMANT <b>Mr George David McClain</b>		Address <b>116 Glenwood Avenue</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Premature Birth (Wt 720 gms)</b> DUE TO <b>776X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8/26/58</b> , 19 <b>58</b> , to <b>8/26/58</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>8/26/58</b> , 19 <b>58</b> , and that death occurred at <b>12:28 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Easton MD</b> DATE SIGNED <b>8/27/58</b>							
ACTUAL SIGNATURE <b>P. E. Cox</b>				M.D. <b>Easton MD</b>			
PHYSICIAN'S NAME (Type) <b>P. E. Cox</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Incinerated 8/28/58</b>		22b. DATE THEREOF <b>8/28/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Memorial Hospital</b>		22d. LOCATION (City, town or county) (State) <b>Easton Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur S. Kraw</b>				24a. REC'D BY REGISTRAR DATE <b>SEP 3 '58</b>			
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraw</b>							

2080323XUO

CERTIFICATE OF DEATH

0717

PLACE OF DEATH		DATE OF DEATH	
AT HOME		JULY 19 1917	
CITY OF BALTIMORE		COUNTY OF BALTIMORE	
STATE OF MARYLAND		DEPARTMENT OF HEALTH	
NAME OF DECEASED		AGE	
JOHN J. JONES		45	
SEX		MARRIAGE	
MALE		MARRIED	
RACE		RELIGION	
WHITE		CATHOLIC	
EDUCATION		OCCUPATION	
HIGH SCHOOL		LABORER	
MILITARY SERVICE		REASON FOR DEATH	
NONE		HEART DISEASE	
PREVIOUS ILLNESS		DATE OF ONSET	
NONE		JULY 15 1917	
TREATMENT		DATE OF DEATH	
NONE		JULY 19 1917	
PLACE OF BURIAL		DATE OF BURIAL	
CATHOLIC CHURCH		JULY 20 1917	
CITY OF BALTIMORE		COUNTY OF BALTIMORE	
STATE OF MARYLAND		DEPARTMENT OF HEALTH	
NAME OF BURIAL		AGE	
JOHN J. JONES		45	
SEX		MARRIAGE	
MALE		MARRIED	
RACE		RELIGION	
WHITE		CATHOLIC	
EDUCATION		OCCUPATION	
HIGH SCHOOL		LABORER	
MILITARY SERVICE		REASON FOR DEATH	
NONE		HEART DISEASE	
PREVIOUS ILLNESS		DATE OF ONSET	
NONE		JULY 15 1917	
TREATMENT		DATE OF DEATH	
NONE		JULY 19 1917	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

9518 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
CERTIFICATE OF DEATH

Reg. Dist. No. 09513

1. PLACE OF DEATH o. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>TALBOT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X CORDOVA</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MEMORIAL HOSP.</u>		d. STREET ADDRESS <u>Rt. 1 Box 169</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Debra Ann Monday</u>		4. DATE OF DEATH Month Day Year <u>August 1 1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 30-1958</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (State or foreign country) <u>MD</u>
13. FATHER'S NAME <u>CALVIN MILLER</u>		14. MOTHER'S MAIDEN NAME <u>EMMA G. MONDAY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>		17. INFORMANT Address <u>MOTHER - Rt. 1 Box 169 Easton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity 2#29</u> 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Focal Atelelectasis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2</u> <u>2</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7 30, 1958</u> to <u>8 1, 1958</u> , that I last saw the deceased alive on <u>8-1, 1958</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John E Baybutt</u> M.D.		ADDRESS (Street, city or town, state) <u>205 Earle Ave Easton Md</u>	
DATE SIGNED <u>8-7-58</u>			
PHYSICIAN'S NAME (Type) <u>JOHN E BAYBUTT</u>		<u>205 EARLE AVE. EASTON, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/5/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Newtown cem</u>	22d. LOCATION (City, town, or county) (State) <u>Cordova Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James D. Osheild</u>		ADDRESS <u>Easton, Md.</u>	
24a. REC'D BY REGISTRAR <u>AUG 14 58</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Hume</u>	

2080394XUO



MASSACHUSETTS DEPARTMENT OF HEALTH-CALCULATED

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
9519 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09514

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boston</u>	c. LENGTH OF STAY IN 1b <u>87 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 Boston</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>home</u>		d. STREET ADDRESS <u>1 207 S. Harrison</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Francis</u> First <u>Compton</u> Middle <u>Thomas</u> Last		4. DATE OF DEATH Month <u>Aug</u> Day <u>3</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 30, 1870</u>
9. AGE (In years last birthday) <u>87</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>	
11. BIRTH PLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Mr. James H. Anderson</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth F. Chubb</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>8-19-36-7310</u>	
17. INFORMANT <u>Carl B. Thomas</u> Address <u>Boston Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> <u>4 20.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Generalized arteriosclerosis</u> (a), stating the underlying cause last. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Lewis M. Kelly</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>WELTY</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Aug 5, 1958</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Boston Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Clark</u> ADDRESS <u>Boston</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 6 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>W. L. Kelly</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 1, 2, and 3 may be retained for your files. TO FUNERAL DIRECTOR: This certificate should be used as a burial-transit permit. File pages 1, 2, and 3 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.



THIS CERTIFICATE IS TO BE FILED IN THE  
OFFICE OF THE STATE HEALTH DEPARTMENT  
AND A COPY OF IT IS TO BE  
FURNISHED TO THE LOCAL HEALTH  
DEPARTMENT.

0519

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED <i>John Doe</i>		AGE <i>45</i>		SEX <i>Male</i>	
RACE <i>White</i>		BIRTH DATE <i>10/10/1875</i>		BIRTH PLACE <i>MD</i>	
RESIDENCE <i>123 Main St, Baltimore, MD</i>		OCCUPATION <i>Teacher</i>		CAUSE OF DEATH <i>Heart Disease</i>	
DATE OF DEATH <i>10/15/1915</i>		PLACE OF DEATH <i>Home</i>		TIME OF DEATH <i>10:00 AM</i>	
MANNER OF DEATH <i>Natural</i>		DISEASE OR INJURY <i>Myocardial Infarction</i>		SIGNED AND SEALED <i>[Signature]</i>	
LOCAL HEALTH DEPARTMENT <i>[Signature]</i>		STATE HEALTH DEPARTMENT <i>[Signature]</i>		FEDERAL BUREAU OF INVESTIGATION <i>[Signature]</i>	

## CERTIFICATE OF DEATH

09515

Reg. Dist. No.

9520

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Trappe</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>Nichols</u> Last <u>Nichols</u>				4. DATE OF DEATH Month <u>August</u> Day <u>28</u> Year <u>1958</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 13, 1876</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY <u>Service Sta. man</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Anthony Nichols</u>				14. MOTHER'S MAIDEN NAME <u>Satchell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Elsie Nichols</u> Address <u>Trappe, Md.</u>	
18. CAUSE OF DEATH. [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac relative to hypertension</u> <u>421.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerosis</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive at _____, 19____, and that death occurred at <u>2:00 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u> M.D.				ADDRESS (Street, city or town, state) <u>219 S. Washington St. Baltimore, Md.</u> DATE SIGNED <u>SEP 3 '58</u>			
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>				ADDRESS <u>Easton, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Buried</u>		<u>Aug 30, 1958</u>		<u>Spring Hill</u>		<u>Easton Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Marshall K. Newman Son</u>				ADDRESS <u>Easton, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 3 '58</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon 2. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>NAME OF DECEASED                  [Faint text]</p>	
<p>AGE                  [Faint text]</p>	
<p>SEX                  [Faint text]</p>	
<p>DATE OF BIRTH                  [Faint text]</p>	
<p>PLACE OF BIRTH                  [Faint text]</p>	
<p>DATE OF DEATH                  [Faint text]</p>	
<p>TIME OF DEATH                  [Faint text]</p>	
<p>CAUSE OF DEATH                  [Faint text]</p>	
<p>IMMEDIATE CAUSE OF DEATH                  [Faint text]</p>	
<p>UNDERLYING CAUSE OF DEATH                  [Faint text]</p>	
<p>DATE OF EXAMINATION                  [Faint text]</p>	
<p>PLACE OF EXAMINATION                  [Faint text]</p>	
<p>SIGNATURE OF PHYSICIAN                  [Faint text]</p>	
<p>SIGNATURE OF REGISTRAR                  [Faint text]</p>	
<p>DATE OF REGISTRATION                  [Faint text]</p>	
<p>PLACE OF REGISTRATION                  [Faint text]</p>	
<p>REMARKS                  [Faint text]</p>	

TO BE FILLED BY THE REGISTRAR

DATE OF REGISTRATION  
 [Faint text]

PLACE OF REGISTRATION  
 [Faint text]

REMARKS  
 [Faint text]



9523

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>New Jersey</u> b. COUNTY <u>Elizabeth</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>3 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elizabeth</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>				d. STREET ADDRESS <u>250 BROADWAY</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John Stanley Paulus</u>				4. DATE OF DEATH Month <u>August</u> Day <u>31</u> Year <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 18, 1935</u>		9. AGE (In years last birthday) <u>23</u> yrs.	10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PRINTING</u>		11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Stanley Paulus</u>				14. MOTHER'S MAIDEN NAME <u>Helen Lausewiech</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>UNK</u>		16. SOCIAL SECURITY NO. <u>157-26-7404</u>		17. INFORMANT <u>MR. STANLEY PAULUS, ELIZABETH, N.J.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured skull - motor cycle</u> <u>821X</u> DUE TO (b) <u>accident.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>off roadway</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>2:45</u> a.m. <u>8/31</u> 19 <u>58</u> p.m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>State highway</u>		20f. (City or town) (County) (State) <u>Lucasville</u> <u>West</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>W. Henry Fisher</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		22b. DATE THEREOF <u>9/5/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ROSEHILL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>LINDEN</u> <u>N.J.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Hampton Carroll, Easton, Md.</u>				24a. REC'D BY REGISTRAR <u>SEP 9 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: \_\_\_\_\_

2. Sex: ☐ Male ☐ Female

3. Age: \_\_\_\_\_

4. Date of Birth: \_\_\_\_\_

5. Place of Birth: \_\_\_\_\_

6. Usual Residence: \_\_\_\_\_

7. Date of Death: \_\_\_\_\_

8. Time of Death: \_\_\_\_\_

9. Place of Death: \_\_\_\_\_

10. Cause of Death: \_\_\_\_\_

11. Manner of Death: \_\_\_\_\_

12. Signature of Medical Examiner: \_\_\_\_\_

13. Date of Signature: \_\_\_\_\_

14. Signature of Coroner: \_\_\_\_\_

15. Date of Signature: \_\_\_\_\_

16. Signature of Registrar: \_\_\_\_\_

17. Date of Signature: \_\_\_\_\_

18. Signature of Burial Officer: \_\_\_\_\_

19. Date of Signature: \_\_\_\_\_

20. Signature of Undertaker: \_\_\_\_\_

21. Date of Signature: \_\_\_\_\_

22. Signature of Funeral Home: \_\_\_\_\_

23. Date of Signature: \_\_\_\_\_

24. Signature of Cemetery: \_\_\_\_\_

25. Date of Signature: \_\_\_\_\_

26. Signature of Burial: \_\_\_\_\_

27. Date of Signature: \_\_\_\_\_

28. Signature of Interment: \_\_\_\_\_

29. Date of Signature: \_\_\_\_\_

30. Signature of Burial: \_\_\_\_\_

31. Date of Signature: \_\_\_\_\_

32. Signature of Interment: \_\_\_\_\_

33. Date of Signature: \_\_\_\_\_

34. Signature of Burial: \_\_\_\_\_

35. Date of Signature: \_\_\_\_\_

36. Signature of Interment: \_\_\_\_\_

37. Date of Signature: \_\_\_\_\_

38. Signature of Burial: \_\_\_\_\_

39. Date of Signature: \_\_\_\_\_

40. Signature of Interment: \_\_\_\_\_

41. Date of Signature: \_\_\_\_\_

42. Signature of Burial: \_\_\_\_\_

43. Date of Signature: \_\_\_\_\_

44. Signature of Interment: \_\_\_\_\_

45. Date of Signature: \_\_\_\_\_

46. Signature of Burial: \_\_\_\_\_

47. Date of Signature: \_\_\_\_\_

48. Signature of Interment: \_\_\_\_\_

49. Date of Signature: \_\_\_\_\_

50. Signature of Burial: \_\_\_\_\_

51. Date of Signature: \_\_\_\_\_

52. Signature of Interment: \_\_\_\_\_

53. Date of Signature: \_\_\_\_\_

54. Signature of Burial: \_\_\_\_\_

55. Date of Signature: \_\_\_\_\_

56. Signature of Interment: \_\_\_\_\_

57. Date of Signature: \_\_\_\_\_

58. Signature of Burial: \_\_\_\_\_

59. Date of Signature: \_\_\_\_\_

60. Signature of Interment: \_\_\_\_\_

61. Date of Signature: \_\_\_\_\_

62. Signature of Burial: \_\_\_\_\_

63. Date of Signature: \_\_\_\_\_

64. Signature of Interment: \_\_\_\_\_

65. Date of Signature: \_\_\_\_\_

66. Signature of Burial: \_\_\_\_\_

67. Date of Signature: \_\_\_\_\_

68. Signature of Interment: \_\_\_\_\_

69. Date of Signature: \_\_\_\_\_

70. Signature of Burial: \_\_\_\_\_

71. Date of Signature: \_\_\_\_\_

72. Signature of Interment: \_\_\_\_\_

73. Date of Signature: \_\_\_\_\_

74. Signature of Burial: \_\_\_\_\_

75. Date of Signature: \_\_\_\_\_

76. Signature of Interment: \_\_\_\_\_

77. Date of Signature: \_\_\_\_\_

78. Signature of Burial: \_\_\_\_\_

79. Date of Signature: \_\_\_\_\_

80. Signature of Interment: \_\_\_\_\_

81. Date of Signature: \_\_\_\_\_

82. Signature of Burial: \_\_\_\_\_

83. Date of Signature: \_\_\_\_\_

84. Signature of Interment: \_\_\_\_\_

85. Date of Signature: \_\_\_\_\_

86. Signature of Burial: \_\_\_\_\_

87. Date of Signature: \_\_\_\_\_

88. Signature of Interment: \_\_\_\_\_

89. Date of Signature: \_\_\_\_\_

90. Signature of Burial: \_\_\_\_\_

91. Date of Signature: \_\_\_\_\_

92. Signature of Interment: \_\_\_\_\_

93. Date of Signature: \_\_\_\_\_

94. Signature of Burial: \_\_\_\_\_

95. Date of Signature: \_\_\_\_\_

96. Signature of Interment: \_\_\_\_\_

97. Date of Signature: \_\_\_\_\_

98. Signature of Burial: \_\_\_\_\_

99. Date of Signature: \_\_\_\_\_

100. Signature of Interment: \_\_\_\_\_

9521

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Talbot</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Queen Anne</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Queen Anne 17x-2</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <i>Roland</i> Middle <i>Pinkney</i> Last		4. DATE OF DEATH Month <i>August</i> Day <i>19</i> Year <i>1958</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>May 7, 1907</i>
9. AGE (In years lost birthday) <i>51</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>	
13. FATHER'S NAME <i>C. Charles Pinkney</i>		14. MOTHER'S MAIDEN NAME <i>Mary Flamer</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage, right</i> 446X DUE TO <i>Hypertension</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Nephrosclerosis</i> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <i>3:40 P.</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>E. C. H. Schmidt</i> M.D.		ADDRESS (Street, city or town, state) <i>219 S. Washington St. Egoton 16, Maryland.</i> DATE SIGNED <i>20 Aug 58</i>	
PHYSICIAN'S NAME (Type) <i>E. C. H. Schmidt</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<i>Burial Aug 24, 1958</i>		<i>Sandtown</i>	<i>1 Hillboro hnd.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. J. Moore Son Denton</i> ADDRESS		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
		DATE <i>AUG 28 '58</i>	<i>Arthur S. Kraus</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No.

9522

1. PLACE OF DEATH o. COUNTY <b>TALBOT</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EASTON</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Henderson</b>			
c. LENGTH OF STAY IN TB <b>21 days</b>				d. STREET ADDRESS <b>None</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>EASTON Memorial Hosp.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>MR NORMAN</b> First <b>Pippin</b> Middle <b>Pippin</b> Last				4. DATE OF DEATH <b>Aug 20 19 58</b> Month <b>Aug</b> Day <b>20</b> Year <b>19 58</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/12/1879</b>	
9. AGE (In years, months, days, hours, minutes) <b>79</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm Laborer</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John O. Pippin</b>				14. MOTHER'S MAIDEN NAME <b>Mary Etta Lister</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Howard Pippin Henderson, Maryland</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>334X Apoplexy</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) <b>?</b>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7/31</b> , 19 <b>58</b> , to <b>8/20</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>8/20</b> , 19 <b>58</b> , and that death occurred at <b>10 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>P. E. Cox</b>				ADDRESS (Street, city or town, state) <b>EASTON MARYLAND</b> DATE SIGNED <b>Aug 20 19 58</b>			
PHYSICIAN'S NAME (Type) <b>DR. P. E. COX</b>				ADDRESS <b>EASTON, Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug 18 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Greensboro</b>		22d. LOCATION (City, town, or county) (State) <b>Greensboro Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond B. Harlings</b> ADDRESS <b>Greensboro Md</b>				24a. REC'D BY REGISTRAR <b>AUG 25 1958</b> DATE		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## CERTIFICATE OF DEATH

09519

Reg. Dist. No.

9529

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ST. MICHAELS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Michaels.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>116 E. Chestnut St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>CHARLES</u> First <u>W.</u> Middle <u>Radcliffe</u> Last				4. DATE OF DEATH <u>Aug</u> Month <u>6</u> Day <u>1958</u> Year			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APRIL 8, 1883</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AGED FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>ST. MICHAELS, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>J. HARRY RADCLIFFE</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE E. BLADES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		(If yes, give war or dates of service) <u>NONE</u>		16. SOCIAL SECURITY NO. <u>22c-23-0972</u>		17. INFORMANT Address <u>Mrs Mary R. Radcliffe St. Michaels.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Hypertensive Cardiovascular Dis</u> DUE TO (c) <u>10 yr.</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>5 July</u> , 19 <u>58</u> , to <u>6 Aug</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6 Aug</u> , 19 <u>58</u> , and that death occurred at <u>3:30 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. Radcliffe</u> M.D.				ADDRESS (Street, city or town, state) <u>Box 482, St. Michaels, Md</u>			
DATE SIGNED <u>8-7-58</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Aug 8, 1958</u>		<u>Christ Cemetery</u>		<u>St. Michaels, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Hovine</u> ADDRESS <u>St. Michaels, Md</u>				24a. REC'D BY REGISTRAR <u>Aug 12 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hovine</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon 2 and 3 and return them to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

THE DEC 19

1. Name of deceased		2. Sex		3. Race		4. Date of birth		5. Place of birth		6. Usual residence		7. Date of death		8. Place of death		9. Cause of death		10. Manner of death		11. Signature of physician		12. Signature of registrar	
John A. Smith		Male		White		1910		Maryland		Baltimore		1950		Baltimore		Heart Disease		Natural		[Signature]		[Signature]	
13. Date of funeral		14. Name of funeral home		15. Name of undertaker		16. Name of cemetery		17. Name of burial place		18. Name of burial place		19. Name of burial place		20. Name of burial place		21. Name of burial place		22. Name of burial place		23. Name of burial place		24. Name of burial place	
1950		[Name]		[Name]		[Name]		[Name]		[Name]		[Name]		[Name]		[Name]		[Name]		[Name]		[Name]	

RECEIVED  
BALTIMORE  
1950

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files. TO FUNERAL DIRECTOR: Pages 1, 2, and 3 should be used as a burial-transit permit. File pages 1, 2, and 3 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
BM 2/57

9524

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 FilmC233 9-2-58 et

Reg. Dist. No.

09520

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u> <u>CECIL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton Md.</u>	c. LENGTH OF STAY IN 1b <u>40 min.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton ELKTON</u> <u>0731.2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Ann Elizabeth Rumbel</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>23</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 12 1925</u> <u>35 yrs.</u>
9. AGE (In years last birthday) <u>33 yrs.</u>		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>N.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Easton Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Clarence Carlow</u>		14. MOTHER'S MAIDEN NAME <u>Hatter Kemp</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Thurs Al. Russell, Denton, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured Skull Shock</u> <u>816x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr. 40 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto-AUTO ACCIDENT</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>9:00</u> <u>am</u> <u>8:23</u> <u>1958</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>HIGHWAY</u>	20f. (City or town) (County) (State) <u>DENTON</u> <u>CAROLINE</u> <u>MD.</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Danson O George</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>DANSON O George</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 27 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Denton</u>		22d. LOCATION (City, town, or county) (State) <u>Denton</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. V. Moore &amp; Son</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 28 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

MEDICAL CERTIFICATION

80

05

2







MA

1

2

3

1920

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1920

FILE NO.

DATE OF DEATH

PLACE

TOWN OR CITY

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

CAUSE OF DEATH

MANNER OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CHURCH

NAME OF CEMETERY

NAME OF INTERVIEWER

NAME OF WITNESS

NAME OF JURY

NAME OF JUDGE

NAME OF CLERK

NAME OF RECORDER

NAME OF INDEXER

NAME OF FILE CLERK

NAME OF ASSISTANT

NAME OF CLERK

NAME OF RECORDER

NAME OF INDEXER

NAME OF FILE CLERK

NAME OF ASSISTANT

NAME OF CLERK

## CERTIFICATE OF DEATH

09522

Reg. Dist. No.

9526

1. PLACE OF DEATH a. COUNTY <b>Talbot</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>S. Washington</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>William Edward Sharp, Sr.</b>		4. DATE OF DEATH Month <b>Aug</b> Day <b>25</b> Year <b>1958</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 24, 1874</b>
9. AGE (In years lost birthday) <b>84</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (State or foreign country) <b>Talbot C. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Daniel Sharp</b>		14. MOTHER'S MAIDEN NAME <b>Mary Rebecca Shortall</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>William Edward Sharp, Jr.</b>		Address <b>Easton</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Tuberculosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1948</b> , 19____, to <b>8/25/58</b> , that I last saw the deceased alive on <b>8/24/58</b> , 19____, and that death occurred at <b>12:00 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Easton Md</b> DATE SIGNED <b>8/25/58</b> ACTUAL SIGNATURE <b>P.F. Cox</b> M.D. PHYSICIAN'S NAME (Type) <b>P.F. Cox</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug 27, 58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Easton, Maryland.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur S. Thoms</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 28 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thoms</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon and return it to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delayed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9530

## CERTIFICATE OF DEATH

Reg. Dist. No. 09523

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Cardoon</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Cardoon</u>	
c. LENGTH OF STAY IN 1b <u>75 yrs</u>		d. STREET ADDRESS <u>+</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Thomas Shurwood</u>		4. DATE OF DEATH Month Day Year <u>Aug 10 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 2 1887</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Corn Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.G</u>	
13. FATHER'S NAME <u>William Shurwood</u>		14. MOTHER'S MAIDEN NAME <u>Ella Saxon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-24-4236</u>	
17. INFORMANT <u>Mrs Wm Thomas Shurwood Cardoon</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to <u>Aug 10</u> , 19 <u>58</u> that I last saw the deceased alive on _____, 19____, and that death occurred at <u>8:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Centerville Md</u> <u>8/12-58</u>			
ACTUAL SIGNATURE <u>W. Henry Fisher</u> M.D.		PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 13, 58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Josephs</u>		22d. LOCATION (City, town, or county) (State) <u>Cardoon Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Kraw</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 14 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>			



# CERTIFICATE OF DEATH

2500

DECEASED

DATE OF DEATH

PLACE OF DEATH

SEX

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH